Statement of
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Representing

THE STATE OF MICHIGAN

Before the

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
of the
U.S. HOUSE ENERGY AND COMMERCE COMMITTEE

Hearing on

MEDICAID PRESCRIPTION DRUG REIMBURSEMENT: WHY THE GOVERNMENT PAYS TOO MUCH

December 7, 2004

Good morning Mr. Chairman and distinguished members of the Subcommittee. I want to thank you for this opportunity to discuss the Michigan Medicaid pharmacy program. My name is Paul Reinhart and I am the director of the Michigan Medicaid program. Prior to working in this capacity in Governor Granholm's Administration, I served as the Director of the Office of Health and Human Services in Governor Engler's Department of Management and Budget.

While we work very hard to constrain cost increases in all areas of the Medicaid program, our pharmacy cost containment efforts have been particularly effective and I appreciate the opportunity to tell you about them. I would also like to discuss the effect the Medicare Modernization Act will have on our ability to constrain Medicaid costs.

Pharmacy Cost Containment Programs

As you know, each state chooses a reimbursement methodology for its Medicaid program. The Michigan Medicaid program utilizes many strategies to hold down the costs of the pharmacy benefit, but the three major initiatives we have used in Michigan are:

- A preferred drug list;
- The multi-state prescription drug purchasing pool; and
- Limiting reimbursements to pharmacists to their actual drug acquisition costs

These initiatives have been extremely successful in constraining our prescription drug costs, producing savings not only for Michigan, but also for the federal government..

In fiscal year 2003, the first year of our preferred drug list program, our per-script cost increase declined from 11% to only 4%. In fiscal year 2004, the first year of the multi-state purchasing initiative, per-beneficiary costs for prescription drugs actually declined about 1%. We believe our aggressive cost containment programs reduced pharmacy spending in fiscal year 2004 from $770 million to $640 million, a savings of $130 million.

I have attached some charts at the back of this presentation that detail these trends.

Preferred Drug List

The Michigan Medicaid program, like a growing list of states, uses a preferred drug list (PDL) to discourage physicians from prescribing high cost drugs when lower cost, but equally effective, drugs are available. Michigan instituted the PDL in the last quarter of fiscal year 2002. A "Pharmacy and Therapeutics Committee" of physicians and pharmacists appointed by the Governor uses evidence-based information to decide which drugs will be included on the preferred list. Drugs not on the list are, of course available, but the prescribing physician must secure prior authorization from our pharmacy benefit manager or from one of the physicians employed by the Medicaid agency. This program

has substantially increased the use of generic drugs. Generic drugs now account for well over 50% of the drugs paid for by the Michigan Medicaid program.

Multi-State Prescription Drug Purchasing Pool

The ability of the preferred drug list to generate savings is greatly enhanced by our multi-state pharmaceutical purchasing program. When Governor Jennifer Granholm began her term in January of 2003, she directed the Michigan Medicaid agency to develop a multi-state pharmaceutical purchasing program. She felt that manufacturers would be willing to give state Medicaid programs a better price for their products in exchange for access to a larger market. And she was right.

In mid-2003, Michigan and Vermont began a joint purchasing program for Medicaid prescription drugs and asked the Centers for Medicare and Medicaid Services (CMS) for permission to add additional states to the program. After a frustrating series of delays, in April of 2004, CMS finally authorized Michigan, Vermont, Nevada, Alaska and New Hampshire to create an even larger pool and jointly negotiate better prices from pharmaceutical manufacturers. This new larger pool generated price discount proposals from over 40 manufacturers (when only two states were involved in FY03, 26 pharmaceutical manufacturers submitted discounted price proposals). These new prices are estimated to save Michigan an additional $13 million per year on prescription drugs. CMS has also recently authorized Minnesota and Hawaii to join the pool, which should

produce further savings when prices are renegotiated with pharmaceutical manufacturers next year.

We strongly encourage CMS to expedite approvals of additional states that want to enter the pool. This will allow additional cost savings to both state and federal governments.

Limiting Product Reimbursements to Pharmacists

In addition to the efforts just discussed, we have generated substantial savings in Michigan by limiting product reimbursements paid to pharmacists to the pharmacist's actual product acquisition cost.

We accomplish this in two ways. First, our payment for brand name drugs is set at the AWP, or "average wholesale price" less 13.5%/15.5% depending on the size of the pharmacy. Any pharmacist who is willing to accept this level of reimbursement is able to participate in the Medicaid program. This practice has been in place since fiscal year 2000.

Second, we use a contractor to adjust payments for generic drugs on a daily basis to the actual acquisition costs for that day. This is a practice also known as "maximum allowable cost, or "MAC" pricing. Michigan began aggressive daily MAC pricing in October 2004.

Michigan's successful program was recognized by the 2004 Department of Health and Human Services' Office of Inspector General report that concluded Michigan had the lowest product reimbursement costs in the country.

Medicare Modernization Act

I would now like to briefly discuss how the Medicare Modernization Act (MMA) will impact state Medicaid programs' ability to constrain prescription drug cost increases. Not surprisingly, we had hoped that a Medicare pharmacy benefit would relieve states of the responsibility of paying for the drugs used by Medicaid-Medicare dual eligibles--or at the very least that the benefit would not increase our pharmacy costs for these dual eligibles. While the MMA certainly contains many positive aspects, we have concluded that it, unfortunately, will increase our costs in Michigan.

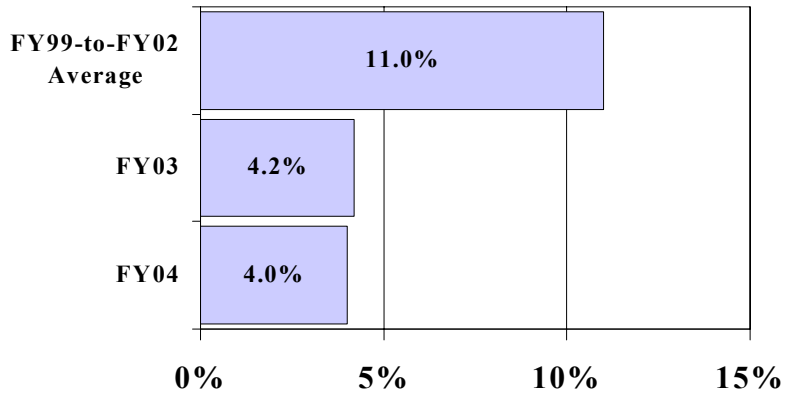
The MMA requires states to continue subsidizing the pharmacy benefit for dual eligibles. While prescription drug costs for dual eligibles will be covered by Medicare Part D, states will be responsible for making monthly payments back to the Department of Health and Human Services for a large portion of the drug expenditures for these individuals. This financing mechanism is also known as the "clawback," or what some call a "reverse block grant." States will be required to pay the federal government for 90 percent of the state portion of dual elgibles' pharmacy costs in 2006, 88.333 percent in 2007, and this amount continues to gradually decline to 75% in 2014. The Department of Health and Human Services (HHS) will determine the state payment amount and base part of the

formula on double digit growth factors (National Health Expenditures and then average per-capita expenditures for Part D drugs) which will be considerably higher than the low, single digit growth rates we have been able to achieve in Michigan for prescription drugs. We estimate that the clawback will increase state costs by $20 million in fiscal year 2006 and $30 million in fiscal year 2007 (see attached chart). In Michigan, this is quite a blow because we have been so effective managing these costs.

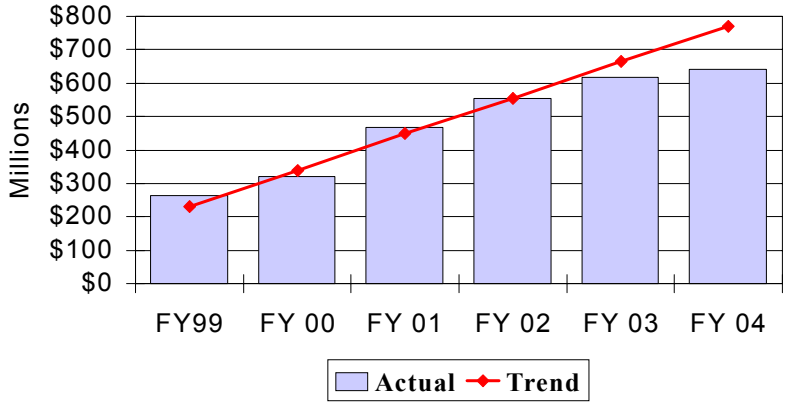
Additionally, since Medicare will manage the pharmacy benefit for dual eligibles, the size of our multi-state purchasing pool will be significantly reduced, which means our ability to leverage better Medicaid pharmaceutical prices from manufacturers will be reduced. The other states in our pool will find that their Medicaid savings will be greatly affected too.

I hope my remarks today demonstrate that, at least in Michigan, we are not paying too much for the pharmaceutical products used by our beneficiaries, but rather, we have been very proactive, aggressive, and successful in our cost containment initiatives. Thank you for the opportunity to share our experiences. I would be happy to answer any questions.

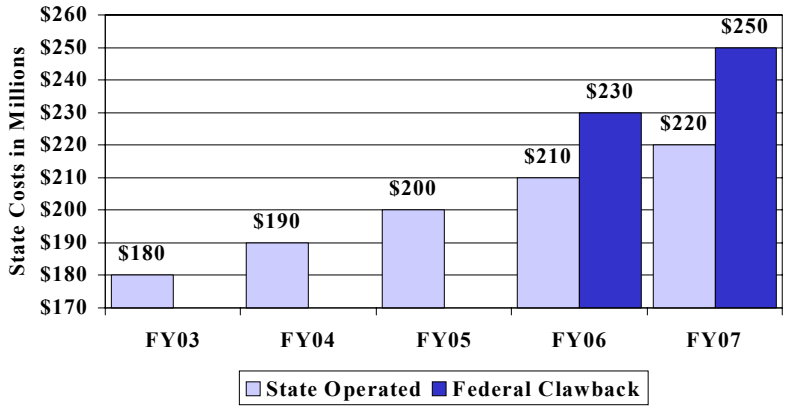
Annual Cost Per Script Increase



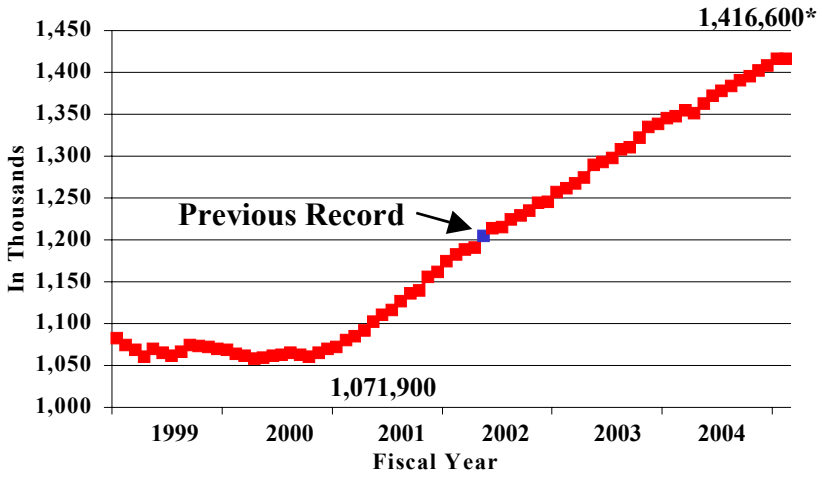
Estimated Pharmacy Cost Containment Savings



"Clawback" Will Increase Michigan's Costs



Michigan Medicaid Caseload



*November 2004